

SERFF Tracking Number:	PNAL-127029274	State:	Arkansas
Filing Company:	Pan-American Life Insurance Company	State Tracking Number:	48014
Company Tracking Number:	SJL-480		
TOI:	L08 Life - Other	Sub-TOI:	L08.000 Life - Other
Product Name:	Applications B1500 and B1501		
Project Name/Number:	Applications B-1500, B-1501/SJL-480		

## Filing at a Glance

Company: Pan-American Life Insurance Company

Product Name: Applications B1500 and B1501 SERFF Tr Num: PNAL-127029274 State: Arkansas

TOI: L08 Life - Other SERFF Status: Closed-Approved- State Tr Num: 48014  
Closed

Sub-TOI: L08.000 Life - Other Co Tr Num: SJL-480 State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird

Author: San Llull Disposition Date: 02/23/2011

Date Submitted: 02/17/2011 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Applications B-1500, B-1501

Project Number: SJL-480

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 02/23/2011

State Status Changed: 02/23/2011

Deemer Date:

Created By: San Llull

Submitted By: San Llull

Corresponding Filing Tracking Number:

Filing Description:

Previously approved Applications have been altered to add questions concerning STOLI and Anti-Money Laundering.

## Company and Contact

### Filing Contact Information

San Llull, Senior Compliance and Policy

slull@panamericanlife.com

Analyst

601 Poydras Street

504-566-3449 [Phone]

28th Floor

504-566-3600 [FAX]

New Orleans, LA 70130

SERFF Tracking Number: PNAL-127029274 State: Arkansas

Filing Company: Pan-American Life Insurance Company State Tracking Number: 48014

Company Tracking Number: SJL-480

TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other

Product Name: Applications B1500 and B1501

Project Name/Number: Applications B-1500, B-1501/SJL-480

### Filing Company Information

Pan-American Life Insurance Company	CoCode: 67539	State of Domicile: Louisiana
601 Poydras Street	Group Code: 525	Company Type: Life and Health
New Orleans, LA 70130	Group Name:	State ID Number:
(504) 566-3449 ext. [Phone]	FEIN Number: 72-0281240	

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### Filing Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Pan-American Life Insurance Company	\$0.00	02/17/2011	
Pan-American Life Insurance Company	\$100.00	02/22/2011	44919946

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	02/23/2011	02/23/2011

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	02/18/2011	02/18/2011	San Llull	02/22/2011	02/22/2011

<i>SERFF Tracking Number:</i>	<i>PNAL-127029274</i>	<i>State:</i>	<i>Arkansas</i>
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## Disposition

Disposition Date: 02/23/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

<i>SERFF Tracking Number:</i>	<i>PNAL-127029274</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Pan-American Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>48014</i>
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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification		No
<b>Supporting Document</b>	Application		No
<b>Supporting Document</b>	AR Cover letter		No
<b>Form</b>	Primary Application		No
<b>Form</b>	Supplementary Application		No

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*TOI:* L08 Life - Other *Sub-TOI:* L08.000 Life - Other  
*Product Name:* Applications B1500 and B1501  
*Project Name/Number:* Applications B-1500, B-1501/SJL-480

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 02/18/2011  
Submitted Date 02/18/2011  
Respond By Date 03/18/2011

Dear San Llull,

This will acknowledge receipt of the captioned filing.

### Objection 1

Comment: Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the \$100.00 filing fee is received.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

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Product Name: Applications B1500 and B1501  
Project Name/Number: Applications B-1500, B-1501/SJL-480

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 02/22/2011  
Submitted Date 02/22/2011

Dear Linda Bird,

### Comments:

I have authorized \$100.00 payment for the filing fees.

Thank you

San Llull

## Response 1

Comments: I have authorized \$100.00 payment for the filing fees.

### Related Objection 1

Comment:

Regulation 57 was revised effective January 2010, the filing fee is now \$50.00 per form. We will hold your filing in a pending status until the \$100.00 filing fee is received.

### Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

I have authorized \$100.00 payment for the filing fees.

Sincerely,

San Llull

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## Form Schedule

### Lead Form Number: B-1500

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	B-1500(AR) Rev 01-11	Application/ Enrollment Form	Primary Application	Initial		52.450	B1500 (AR) Rev 01-11.pdf
	B-1501(AR) Rev 01-11	Application/ Enrollment Form	Supplementary Application	Initial		52.450	B1501 (AR) Rev 01-11.pdf





☐ Pan-American Life Insurance Company

☐ Pan-American Assurance Company

P.O. Box 60219, New Orleans, LA 70160 USA

Part I of Application (Please print)

**PRIMARY PROPOSED INSURED**

1. a) Last Name		b) First Name		c) M. I.	d) Date of Birth	e) Age	f) Gender <input type="checkbox"/> M <input type="checkbox"/> F
g) Social Security Number / Cedula		h) State of Birth	i) Country of Birth (If other than US)		j) Citizenship		k) US Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No
l) Residential Address		m) City		n) State/Province	o) Zip Code	p) Telephone Number	
q) E-Mail Address		r) Driver's License Number		s) D.L. State	t) Current Annual Income \$ _____	u) Net Worth \$ _____	
v) Risk Classification (Choose only one from the choices below.) <input type="checkbox"/> Preferred Plus Non-Tobacco <input type="checkbox"/> Preferred Non-Tobacco <input type="checkbox"/> Standard Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Standard Tobacco							
2. a) Name of Business (If independent professional, indicate profession.)				b) Nature of Business			
c) Business Address		d) City		e) State/Province	f) Zip Code	g) Business Phone	
h) Describe exact duties/functions of Proposed Insured's work.						i) How long in present job?	
j) Presently working? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If "No," please explain under question 15, Special Instructions.</small>		k) Other employment in last 3 years		l) Percentage of time traveling and places traveled			
3. Send premium notices & correspondence to: <input type="checkbox"/> Insured's Address <input type="checkbox"/> Business Address <input type="checkbox"/> Owner's Address <input type="checkbox"/> Other Address (Provide address under question 15, Special Instructions.)				4. Policy date requested (1st to 28th only)			
5. Name of secondary addressee for the purpose of notification of past due premium payment and possible lapse in coverage.							
a) Full Name		b) Residential Address		c) City		d) State/Province	e) Zip Code

**PRIMARY PROPOSED INSURED BENEFICIARIES**

6. a) Full Name of Primary Beneficiary	D.O.B.	Relationship	%	b) Full Name of Contingent Beneficiary	D.O.B.	Relationship	%

If you would like the beneficiary designation to be irrevocable, please indicate this under question 15, Special Instructions.

**POLICY OWNER** (Complete question 7 only if Policy Owner is not Primary Proposed Insured.)

7. a) Last Name		b) First Name		c) M. I.	d) Date of Birth	
e) Residential Address		f) City		g) State/Province	h) Zip Code	i) Telephone Number
j) Social Security Number / Cedula		k) E-Mail Address			l) Relationship to Proposed Insured	
m) If a Corporation, State of Incorporation				n) Tax Identification Number		

If you would like a contingent owner, please indicate and include this information under question 15, Special Instructions.

**UNIVERSAL LIFE INSURANCE COVERAGE DETAILS**

<b>8. a) Plan Name:</b> _____	<b>b) Specified Amount \$</b> _____													
<b>c) Death Benefit Option</b> <input type="checkbox"/> Option 1 (Level) <input type="checkbox"/> Option 2 (Specified Amount plus Account Value) <input type="checkbox"/> Option 3 (Specified Amount plus Paid Premium less Withdrawals)														
<b>d) Riders</b> <table style="width: 100%;"><tr><td style="width: 50%;"><input type="checkbox"/> Primary Insured Rider</td><td style="width: 20%;">Specified Amount \$ _____</td><td rowspan="6" style="width: 30%; text-align: center; vertical-align: middle;"><b><i>Do not collect premiums if the Specified Amount plus Riders exceeds \$500,000.</i></b></td></tr><tr><td><input type="checkbox"/> Additional Insured Rider <i>(complete Form B-1501)</i></td><td>Specified Amount \$ _____</td></tr><tr><td><input type="checkbox"/> Accidental Death Benefit Rider</td><td>Specified Amount \$ _____</td></tr><tr><td><input type="checkbox"/> Waiver of Monthly Deductions Rider</td><td></td></tr><tr><td><input type="checkbox"/> Terminal Illness Rider</td><td></td></tr><tr><td><input type="checkbox"/> Other Rider _____</td><td>Specified Amount \$ _____</td></tr></table>		<input type="checkbox"/> Primary Insured Rider	Specified Amount \$ _____	<b><i>Do not collect premiums if the Specified Amount plus Riders exceeds \$500,000.</i></b>	<input type="checkbox"/> Additional Insured Rider <i>(complete Form B-1501)</i>	Specified Amount \$ _____	<input type="checkbox"/> Accidental Death Benefit Rider	Specified Amount \$ _____	<input type="checkbox"/> Waiver of Monthly Deductions Rider		<input type="checkbox"/> Terminal Illness Rider		<input type="checkbox"/> Other Rider _____	Specified Amount \$ _____
<input type="checkbox"/> Primary Insured Rider	Specified Amount \$ _____	<b><i>Do not collect premiums if the Specified Amount plus Riders exceeds \$500,000.</i></b>												
<input type="checkbox"/> Additional Insured Rider <i>(complete Form B-1501)</i>	Specified Amount \$ _____													
<input type="checkbox"/> Accidental Death Benefit Rider	Specified Amount \$ _____													
<input type="checkbox"/> Waiver of Monthly Deductions Rider														
<input type="checkbox"/> Terminal Illness Rider														
<input type="checkbox"/> Other Rider _____	Specified Amount \$ _____													
<b>e) Premiums</b> <i>(Do not collect premiums if Specified Amount plus Riders exceeds \$500,000.)</i> Amount Paid with Application \$ _____ Additional Lump Sum \$ _____ Planned Premium Payment \$ _____														
<b>f) Mode of Premium Payment:</b> <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Monthly Bank Draft   Draft Date: _____ <i>(1st to 28th only)</i> <input type="checkbox"/> Other: _____														

**WHOLE LIFE INSURANCE COVERAGE DETAILS**

<b>9. a) Plan Name:</b> _____	<b>b) Specified Amount \$</b> _____ or Amount purchased by premium of \$ _____																					
<b>c) Riders</b> <table style="width: 100%;"><tr><td style="width: 50%;"><input type="checkbox"/> Waiver of Premium Rider</td><td></td><td rowspan="10" style="width: 30%; text-align: center; vertical-align: middle;"><b><i>Do not collect premiums if the Specified Amount plus Riders exceeds \$500,000.</i></b></td></tr><tr><td><input type="checkbox"/> Accidental Death Benefit Rider</td><td>Specified Amount \$ _____</td></tr><tr><td><input type="checkbox"/> Paid-Up Insurance Rider:</td><td></td></tr><tr><td colspan="2"><input type="checkbox"/> Single Premium Paid-Up Insurance or <input type="checkbox"/> Level Premium Paid-Up Insurance: No. of Years _____</td></tr><tr><td colspan="2"><input type="checkbox"/> Rider Amount of Insurance \$ _____ or <input type="checkbox"/> Amount purchased by premium of \$ _____</td></tr><tr><td><input type="checkbox"/> Dependent Children Rider</td><td>Specified Amount \$ _____</td></tr><tr><td><input type="checkbox"/> Spouse Rider <i>(complete Form B-1501)</i></td><td>Specified Amount \$ _____</td></tr><tr><td><input type="checkbox"/> Renewable &amp; Convertible Term Rider</td><td>Specified Amount \$ _____</td></tr><tr><td><input type="checkbox"/> Terminal Illness Rider</td><td></td></tr><tr><td><input type="checkbox"/> Other Rider _____</td><td>Specified Amount \$ _____</td></tr></table>		<input type="checkbox"/> Waiver of Premium Rider		<b><i>Do not collect premiums if the Specified Amount plus Riders exceeds \$500,000.</i></b>	<input type="checkbox"/> Accidental Death Benefit Rider	Specified Amount \$ _____	<input type="checkbox"/> Paid-Up Insurance Rider:		<input type="checkbox"/> Single Premium Paid-Up Insurance or <input type="checkbox"/> Level Premium Paid-Up Insurance: No. of Years _____		<input type="checkbox"/> Rider Amount of Insurance \$ _____ or <input type="checkbox"/> Amount purchased by premium of \$ _____		<input type="checkbox"/> Dependent Children Rider	Specified Amount \$ _____	<input type="checkbox"/> Spouse Rider <i>(complete Form B-1501)</i>	Specified Amount \$ _____	<input type="checkbox"/> Renewable & Convertible Term Rider	Specified Amount \$ _____	<input type="checkbox"/> Terminal Illness Rider		<input type="checkbox"/> Other Rider _____	Specified Amount \$ _____
<input type="checkbox"/> Waiver of Premium Rider		<b><i>Do not collect premiums if the Specified Amount plus Riders exceeds \$500,000.</i></b>																				
<input type="checkbox"/> Accidental Death Benefit Rider	Specified Amount \$ _____																					
<input type="checkbox"/> Paid-Up Insurance Rider:																						
<input type="checkbox"/> Single Premium Paid-Up Insurance or <input type="checkbox"/> Level Premium Paid-Up Insurance: No. of Years _____																						
<input type="checkbox"/> Rider Amount of Insurance \$ _____ or <input type="checkbox"/> Amount purchased by premium of \$ _____																						
<input type="checkbox"/> Dependent Children Rider	Specified Amount \$ _____																					
<input type="checkbox"/> Spouse Rider <i>(complete Form B-1501)</i>	Specified Amount \$ _____																					
<input type="checkbox"/> Renewable & Convertible Term Rider	Specified Amount \$ _____																					
<input type="checkbox"/> Terminal Illness Rider																						
<input type="checkbox"/> Other Rider _____	Specified Amount \$ _____																					
<b>d) Premium Amount paid with Application \$</b> _____ <i>(Do not collect premiums if Specified Amount plus Riders exceeds \$500,000.)</i>																						
<b>e) <input type="checkbox"/> Automatic Premium Loan</b>																						
<b>f) Mode of Premium Payment:</b> <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Monthly Bank Draft   Draft Date: _____ <i>(1st to 28th only)</i> <input type="checkbox"/> Other: _____																						

**TERM LIFE INSURANCE COVERAGE DETAILS**

<b>10. a) Plan Name:</b> _____	<b>b) Specified Amount \$</b> _____ or Amount purchased by premium of \$ _____											
<b>c) Riders</b> <table style="width: 100%;"><tr><td style="width: 50%;"><input type="checkbox"/> Waiver of Premium Rider</td><td></td><td rowspan="5" style="width: 30%; text-align: center; vertical-align: middle;"><b><i>Do not collect premiums if the Specified Amount plus Riders exceeds \$500,000.</i></b></td></tr><tr><td><input type="checkbox"/> Accidental Death Benefit Rider</td><td>Specified Amount \$ _____</td></tr><tr><td><input type="checkbox"/> Dependent Children Rider</td><td>Specified Amount \$ _____</td></tr><tr><td><input type="checkbox"/> Terminal Illness Rider</td><td></td></tr><tr><td><input type="checkbox"/> Other Rider _____</td><td>Specified Amount \$ _____</td></tr></table>		<input type="checkbox"/> Waiver of Premium Rider		<b><i>Do not collect premiums if the Specified Amount plus Riders exceeds \$500,000.</i></b>	<input type="checkbox"/> Accidental Death Benefit Rider	Specified Amount \$ _____	<input type="checkbox"/> Dependent Children Rider	Specified Amount \$ _____	<input type="checkbox"/> Terminal Illness Rider		<input type="checkbox"/> Other Rider _____	Specified Amount \$ _____
<input type="checkbox"/> Waiver of Premium Rider		<b><i>Do not collect premiums if the Specified Amount plus Riders exceeds \$500,000.</i></b>										
<input type="checkbox"/> Accidental Death Benefit Rider	Specified Amount \$ _____											
<input type="checkbox"/> Dependent Children Rider	Specified Amount \$ _____											
<input type="checkbox"/> Terminal Illness Rider												
<input type="checkbox"/> Other Rider _____	Specified Amount \$ _____											
<b>d) Premium Amount paid with Application \$</b> _____ <i>(Do not collect premiums if Specified Amount plus Riders exceeds \$500,000.)</i>												
<b>e) Mode of Premium Payment:</b> <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Monthly Bank Draft   Draft Date: _____ <i>(1st to 28th only)</i> <input type="checkbox"/> Other: _____												

## EVIDENCE OF INSURABILITY

<b>11. Question must be completed for all (medical/non-medical) insurance.</b>	Yes	No
Have you:		
a) Ever been declined, postponed, rated or modified for life, health or disability insurance?	<input type="checkbox"/>	<input type="checkbox"/>
b) Submitted any application for life, health, or disability insurance or reinstatement of same which is now pending?	<input type="checkbox"/>	<input type="checkbox"/>
c) Ever engaged in any type of flying as pilot or crew member on any aircraft including ultralight planes, or expect to in the future? If "Yes," complete Aviation questionnaire Form B-1200.	<input type="checkbox"/>	<input type="checkbox"/>
d) Participated in any auto or motorcycle racing, scuba diving, parachuting, hang gliding, paragliding, ballooning or expect to in the future? If "Yes," complete Hazardous Sports questionnaire Form B-1201.	<input type="checkbox"/>	<input type="checkbox"/>
e) Within the past five years been convicted of or pleaded guilty to:		
(1) Two or more moving violations and/or accidents?	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes," include Driver's License No. _____		
(2) Driving under the influence of alcohol and/or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
f) Ever been arrested other than for moving violations?	<input type="checkbox"/>	<input type="checkbox"/>
g) If not a US citizen or legal resident of the US and residing permanently outside of the US, do you have any intention of traveling or living in another country in the next two years? If "Yes," indicate where and how long.	<input type="checkbox"/>	<input type="checkbox"/>
h) Are any of the Proposed Insureds residing in a country other than the US:		
(1) Presently in or held any political positions?	<input type="checkbox"/>	<input type="checkbox"/>
(2) Currently in or has served in the Armed Forces?	<input type="checkbox"/>	<input type="checkbox"/>
(3) Currently in or held any governmental positions?	<input type="checkbox"/>	<input type="checkbox"/>
i) (1) In relation to purchasing this policy, have you been offered cash or other valuable consideration as an incentive for you to purchase the policy?	<input type="checkbox"/>	<input type="checkbox"/>
(2) Have there been any representations made to you in connection with the purchase or financing of this policy to the effect that the insurance is free or without cost to you for any period of time?	<input type="checkbox"/>	<input type="checkbox"/>
(3) Does your purchasing this policy include a financing arrangement where a lender or other third party will receive a portion of the death benefit above and beyond the repayment of principle and interest?	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes," provide details below.		

Details of "Yes" answers. Identify question letter and circle applicable items.

**12. Insurance currently in force on each person proposed for insurance (Life, Health, Disability, Long Term Care policies or riders to other policies)**  
**If applicant has indicated existing insurance or annuity contracts on below question, our notice #3535 (NAIC 2000) must be executed.**

Insurance Company	Policy Number	Year of Issue	Amount of Insurance	Accidental Death Amount	Premium Waiver
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

PERSONAL DATA		FAMILY HISTORY							
<b>13 a). PROPOSED INSURED</b>		b) Relationship	Age if living	Age at death	Cause of death	c) Relationship	Age if living	Age at death	Cause of death
Height (Ft/Cm)	Weight (Lbs/Kg)	Father				Brothers			
		Mother				Sisters			

**Answer question 14 if cash intended to be paid with this application.**  
**If "Yes" to either (a) or (b), cash cannot be accepted and conditional receipt must not be given.**

<b>14. Within the past 12 months have you:</b>	Yes	No
a) Been medically diagnosed with or treated for heart trouble, stroke, or cancer, consulted a physician for blood pressure requiring medication, or had an electrocardiogram made for any reason other than a routine physical examination?	<input type="checkbox"/>	<input type="checkbox"/>
b) Are you contemplating hospitalization, surgery or other medical treatment in the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>

**15. Special Instructions**

## HEALTH STATEMENT

16. a) Personal Physician Last Name	b) Personal Physician First Name	c) E-mail Address	
d) Physician's Address	e) City	f) State/Province	g) Zip Code
h) Telephone Number			

17. To the best of your knowledge and belief within the last 10 years, have you been medically diagnosed with or treated for:

MEDICAL CONDITION	Yes	No	MEDICAL CONDITION	Yes	No
a) Disorders of the eyes, glaucoma, cornea? Do not include usual vision correction lenses or routine eye check ups.	<input type="checkbox"/>	<input type="checkbox"/>	l) Skin cancer, surgical scars, non surgical scars, other lesions or disorders of the skin?	<input type="checkbox"/>	<input type="checkbox"/>
b) Disorders of the ears, nose or throat, or hoarseness?	<input type="checkbox"/>	<input type="checkbox"/>	m) Anemia, leukemia, hemophilia, phlebitis, thrombophlebitis or any disorders of the blood, vascular system or spleen? Received a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
c) Seizures, convulsions, stroke, cerebral infarct, TIA, severe migraines, recurrent or unexplained headaches, epilepsy, dizziness, dizzy spells, aneurysm, paralysis, quadriplegia, mental/nervous disorders or any other disorders of the brain?	<input type="checkbox"/>	<input type="checkbox"/>	n) Benign or malignant tumors, cancer, cysts, or lymph gland disorders?	<input type="checkbox"/>	<input type="checkbox"/>
d) Pneumonia, bronchitis, asthma, emphysema, allergies, persistent cough, tuberculosis, blood spitting, hemoptysis, chronic respiratory disorder, or any other respiratory or lung disorders?	<input type="checkbox"/>	<input type="checkbox"/>	o) Do you smoke cigarettes, pipe or cigars, or use tobacco in any form? Indicate quantity and frequency.	<input type="checkbox"/>	<input type="checkbox"/>
e) Urinary or genital disorders, kidney stones, renal failure, renal or kidney infections, urinary tract infections, cysts, prostatitis, or sexually transmitted diseases?	<input type="checkbox"/>	<input type="checkbox"/>	p) Have you quit smoking? Indicate when: <input type="checkbox"/> 1 yr <input type="checkbox"/> 2 yrs <input type="checkbox"/> 3 yrs <input type="checkbox"/> 10 or more	<input type="checkbox"/>	<input type="checkbox"/>
f) Hepatitis, cirrhosis, gallbladder stones, cholecystectomy, cholecystitis or any other disorders of the liver or gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>	q) Have you had an EKG, X-Ray, or other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>
g) Tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	<input type="checkbox"/>	<input type="checkbox"/>	r) Have you within the past five years: 1) Had a check-up, illness, injury or surgery? 2) Been advised to have any diagnostic test or surgery which was not completed? 3) Are you contemplating hospitalization, surgery or other medical treatment in the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
h) Hyperthyroidism, hypothyroidism, thyroiditis, diabetes mellitus type I or II, goiter, hypoglycemia, blood sugar, disorders of the pancreas, parathyroid glands or endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>	s) Has any immediate family member ever been medically diagnosed with or treated for diabetes, cancer, heart disease, or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
i) Duodenal ulcer, gastric ulcer, dyspepsia, indigestion gastritis, intestinal bleeding, diverticulitis or diverticulosis, hemorrhoids, colitis, constipation, esophagitis, hiatal hernia, or any other disorders of the digestive system?	<input type="checkbox"/>	<input type="checkbox"/>	t) Have you been treated for alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
j) High blood pressure, myocardial infarction, heart attacks, murmurs, valve lesions, varicose veins, palpitations, tachycardia, chest pain, coronary heart disease, aneurysm, anemia, rheumatic fever, Chagas disease or any other cardiovascular disorder?	<input type="checkbox"/>	<input type="checkbox"/>	u) Are you currently under observation or treatment by a physician or a medical facility?	<input type="checkbox"/>	<input type="checkbox"/>
k) Arthritis, neuritis, gout, sciatica, rheumatism, or disorders of the muscles, bones, spine, back or joints, herniated discs, rheumatoid arthritis, osteoporosis or immune (connective tissue) diseases?	<input type="checkbox"/>	<input type="checkbox"/>	v) For men over 50 years old: 1) Have you had a prostate check up? 2) Have you had a PSA test? Indicate dates and results below.	N/A	<input type="checkbox"/>
			w) For Women: 1) Disorders of the ovaries, uterus, breast, lumps, abnormal discharge, or any other gynecological or breast disorder? 2) Have you had a mammogram, PAP smear or gynecological check up recently? Indicate dates, name(s) of physician(s) and results. 3) Are you pregnant? Indicate how many weeks (or months): _____	N/A	<input type="checkbox"/>

18. Details of "Yes" answers. Identify question letter and circle applicable items. Include diagnosis, dates, durations, treatments, names, addresses, emails and phone number of doctors or medical facilities.

Question Letter	Diagnosis and treatment of medical conditions or check ups	Name and address/phone/emails of Doctors or Hospitals	Dates

## DECLARATION

To the best of his or her knowledge, information and belief, the Proposed Insured (Parent or Guardian if Proposed Insured is under age 18) and Owner (if other than Proposed Insured, Parent or Guardian) represent that the answers and statements made in Parts I (including any supplementary applications) and II (if Part II is required by the Company) of this application are complete and true. The undersigned agrees that:

1. No waiver or modification of a contract provision or of any of the Company's rights or requirements shall be binding upon the Company unless made in writing and approved by the Company;
2. The acceptance of any issued contract will ratify any changes made by the Company in the space "For Home Office Endorsements." However, changes in plan of insurance, amount, age at issue, classification of risk or benefits will be made only with the Owner's written consent;
3. If, within 60 days from the date of application, no policy is received or I am not notified of approval or rejection, this application shall be deemed declined;
4. \$ \_\_\_\_\_ for life insurance has been paid in cash and the Company's liability will be as stated in the Conditional Receipt.  
(No other receipt will be valid);
5. If no payment is made with this application, there will be no life insurance or liability
  - a) until a policy is delivered;
  - b) until the first full premium is paid during the Insured's lifetime; and
  - c) as long as no change has occurred in the health of any person proposed for insurance that would place that person in a higher risk class than at the time of application for this policy; and
6. Any contract resulting from this application shall be construed in accordance with the laws of the state named below where this application is signed.

## FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject of fines and confinement in prison.

## PROXY

### ***Important: Not to be Completed in States Where Use of Proxy is Prohibited***

*(This section is applicable to Pan-American Life Insurance Policies Only)*

Under the Articles of Incorporation of Pan-American Life Mutual Holding Company, a policyholder of Pan-American Life Insurance Company ("Pan-American Life") is a member of Pan-American Life Mutual Holding Company. If a policy is issued on the above application, I appoint the persons serving in the capacity of Chairman of the Board of Directors of Pan-American Life, the President of Pan-American Life, and the Corporate Secretary of Pan-American Life, as of the date of a Member Meeting, as my agents to cast my vote as a member of Pan-American Life Mutual Holding Company at any meeting held for the election of directors or for any other purposes (but only to the extent that such appointed persons are policyholders of Pan-American Life). This proxy is subject to revocation at any time.

### **19. For Home Office Endorsements (For Home Office use only)**

Signed at (City)			State		Date signed		
Signature of <b>Primary Proposed Insured</b> (Parent or Guardian, if Proposed Insured under age 18) <b>X</b> _____			Signature of <b>Owner</b> (If other than Proposed Insured) (If Corporation or Partnership, Officer or Partner other than Proposed Insured must sign.) <b>X</b> _____				
I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant and that I have personally seen this Proposed Insured under this application. To the best of my knowledge, replacement of insurance <input type="checkbox"/> is <input type="checkbox"/> is not involved in this transaction.							
Signature of Soliciting Agent <b>X</b> _____		Personal Code	Participating %	Signature of Soliciting Agent <b>X</b> _____		Personal Code	Participating %
Soliciting Agent's Printed Name				Soliciting Agent's Printed Name			
Signature of Soliciting Agent <b>X</b> _____		Personal Code	Participating %	Signature of Soliciting Agent <b>X</b> _____		Personal Code	Participating %
Soliciting Agent's Printed Name				Soliciting Agent's Printed Name			

**HIPAA AUTHORIZATION FOR THE USE  
AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I authorize the use and/or disclosure of the protected health information of \_\_\_\_\_ as described below:

1. This authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization: All medical records and other protected health information concerning the above named individual.
2. I authorize the following persons (or class of persons) to disclose the protected health information:  
Any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, benefit manager, medical facility, insurance company, insurance support organization or other health care provider that has provided payment, treatment or services to or on behalf of the above named individual.
3. I authorize the following persons (or class of persons) to receive the protected health information:  
Pan-American Life Insurance Company and/or Pan-American Assurance Company and/or \_\_\_\_\_  
\_\_\_\_\_
4. I understand that, if the protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected.
5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing to Pan-American Life Insurance Company, HIPAA Compliance Officer, 601 Poydras Street, New Orleans, LA 70130. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose the protected health information have acted in reliance upon this authorization.
6. This authorization expires upon six months after the date of signature below.
7. I understand that I do not have to sign this authorization. However, I understand that my claim for benefits or my application for insurance coverage may not be processed until all of the necessary information needed to complete the claims and/or underwriting process has been received by Pan-American.
8. The protected health information will be used or disclosed upon request for the following purposes:  
To furnish the insurer with information necessary to complete the processing of an application for life, health and/or disability insurance, and/or to furnish the insurer with information necessary to complete processing of a life and/or disability claim.
9. I understand that I have a right to inspect and copy the protected health information to be used or disclosed in accordance with the requirements of the federal privacy protection regulations.

I certify that I have received a copy of this authorization.

**MEDICAL INFORMATION BUREAU AUTHORIZATION**

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. ("MIB"), consumer reporting agency or other organization, institution or person that has any records or knowledge of me or my minor child or my health or my minor child's health to give to the Pan-American Life Insurance Company, Pan-American Assurance Company, or its reinsurers any such information in order to evaluate my application for life or disability insurance.

I agree that this authorization shall be valid for 30 months from the date signed.

I know that I may request a copy of this authorization.

I agree that a photographic copy of this authorization shall be as valid as the original.

The Undersigned acknowledges receipt of the Notice Concerning the Medical Information Bureau, the Fair Credit Reporting Act Disclosure, and the Abbreviated Notice of Insurance Information Practices.

I understand that I may be interviewed if an investigative consumer report is prepared in connection with this application.

Signature <b>X</b> _____	Name _____	Date _____
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**PERSONAL HISTORY INTERVIEW INFORMATION**

Please furnish the following information as a personal history interview may be completed in lieu of a commercial inspection report.

Convenient time when Proposed Insured may be reached by phone at:

Home

Business

Has Proposed Insured been informed of a possible telephone call? ☐ Yes ☐ No

E-mail Address

**AGENT'S REPORT**

1. How well do you know Proposed Insured?

- ☐ Well    Years \_\_\_\_\_    ☐ Casually    Years \_\_\_\_\_  
☐ Met on solicitation  
☐ Relative    Relationship \_\_\_\_\_

2. Proposed Insured's estimated annual income:

Current year \$ \_\_\_\_\_

Prior year \$ \_\_\_\_\_

3. Purpose of Insurance

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Family Protection                  | <input type="checkbox"/> Pension Max           | <input type="checkbox"/> Section 419     | <input type="checkbox"/> Retirement Income  |
| <input type="checkbox"/> Income Continuation/Deferred Comp. | <input type="checkbox"/> Split Dollar          | <input type="checkbox"/> Loan Collateral | <input type="checkbox"/> Buy Sell Agreement |
| <input type="checkbox"/> Key Employee                       | <input type="checkbox"/> Gift                  | <input type="checkbox"/> Estate Planning | <input type="checkbox"/> Other _____        |
| <input type="checkbox"/> Executive Bonus                    | <input type="checkbox"/> Mortgage Acceleration | <input type="checkbox"/> IRA Alternative |   |

4. Have you seen each Proposed Insured at the time of completing this application and reviewed forms of identification?? ☐ Yes ☐ No  
If the answer is "No," explain.

5. Other names by which the Proposed Insured(s) is (are) also known (include other last names and maiden names)

6. If any Proposed Insured is under the age of 18, indicate:

- a) With whom do they live? \_\_\_\_\_
- b) How many siblings do they have? \_\_\_\_\_
- c) Is every one of them insured? ☐ Yes ☐ No  
For equal sums? ☐ Yes ☐ No  
Company \_\_\_\_\_ Face amount \$ \_\_\_\_\_
- d) Is the father insured? ☐ Yes ☐ No  
Company \_\_\_\_\_ Face amount \$ \_\_\_\_\_
- e) Is the mother insured? ☐ Yes ☐ No  
Company \_\_\_\_\_ Face amount \$ \_\_\_\_\_

7. Requirements for this application:

	Attached	Ordered
Medical Exam / Paramed	<input type="checkbox"/>	<input type="checkbox"/>
Urinalysis	<input type="checkbox"/>	<input type="checkbox"/>
Blood Chemical Profile	<input type="checkbox"/>	<input type="checkbox"/>
Resting Electrocardiogram	<input type="checkbox"/>	<input type="checkbox"/>
Treadmill (Stress EKG)	<input type="checkbox"/>	<input type="checkbox"/>
Financial Statement	<input type="checkbox"/>	<input type="checkbox"/>
Inspection Report	<input type="checkbox"/>	<input type="checkbox"/>
APS Dr. _____	<input type="checkbox"/>	<input type="checkbox"/>
or		
Hospital _____	<input type="checkbox"/>	<input type="checkbox"/>

8. Comments





P.O. Box 60219, New Orleans, Louisiana 70160

**Pan-American Life Insurance Company  
Pan-American Assurance Company**

### CONDITIONAL RECEIPT

**THIS RECEIPT MUST NOT BE DETACHED UNLESS CASH IS PAID WITH THIS APPLICATION, AMOUNTS OF INSURANCE ARE WITHIN THE LIMITS IN QUESTIONS 8(e), 9(d) and 10(d); AND QUESTIONS 14(a) and 14(b) ARE ANSWERED "NO."**

**ALL PREMIUM CHECKS MUST BE PAYABLE TO THE COMPANY.**

**DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

**Unless each and every term and condition stated on this receipt is fulfilled exactly, no insurance will become effective prior to policy delivery. No agent of the Company, medical examiner, or broker is authorized to alter or waive any of such conditions.**

**Received from \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_**

**the sum of \$ \_\_\_\_\_ in connection with this application for Life Insurance.**

#### **I. Conditions Under Which Insurance May Become Effective Prior to Policy Delivery:**

**Each and every one** of the following conditions must be fulfilled **exactly**:

1. The payment received is an amount sufficient to keep the policy or policies applied for in force for a minimum of one month, including any extra premium required for a risk other than standard, and is for the same amount as stated in the application bearing the same date as this receipt; and
2. All required parts of the application, medical examinations, and tests required by Company rules must be completed within 60 days from the date of the application Part I; and
3. On the Effective Date, as defined below, all persons proposed for insurance were insurable risks exactly as applied for according to the practices of the Company governing the acceptance of risks without modification of plan, premium rate or amount; and
4. Questions 14(a) and 14(b) of the application are answered "No."

#### **II. Conditional Insurance Provided**

If all of the above conditions are met, then insurance will be provided under the terms and conditions of the policy applied for, subject to the limits in this section which apply during the conditional period, in the same manner and subject to the same rights, conditions, and defenses as if the policy applied for had been issued and delivered.

The total amount of conditional insurance (life insurance, accidental death benefits and disability indemnity) payable in connection with applications for all persons proposed for insurance, will not exceed \$500,000 regardless of Face Amount or the applied for amounts. This conditional insurance will take effect on the Effective Date as described.

#### **III. Effective Date of Conditional Insurance**

The Effective Date is defined to be the latest of:

1. The date of completion of the application as required;
2. The date of completion of all medical examinations and tests as required;
3. The Policy Date, if any, requested in the application.

#### **IV. Provisions of Conditional Receipt**

1. If the Company declines to accept the application and issue the policy for the plan and amount and at the rate of premium applied for without modification, there will be no liability on the part of the Company. The Company will then return the amount paid with this application.
2. The Company has 60 days from the date of the application to consider and act on it. If the applicant does not receive notice of approval or rejection of this application within that period, then this application will be deemed to be declined by the Company.
3. This Conditional Receipt will be void if:
  - a. The following information on this receipt does not exactly match the application:
    1. the name of all persons proposed for insurance;
    2. the date;
    3. the description of the payment mode; or
  - b. Altered or modified; or
  - c. Any check or draft given in payment is not honored.
4. The conditional insurance will terminate on the date a policy is delivered to the Owner, whether or not the policy is issued as applied for.

**Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20 \_\_\_\_\_**

Signature of Soliciting Agent

**X** \_\_\_\_\_



**AUTHORIZATION TO MAKE WITHDRAWALS FROM MY ACCOUNT**

Policy Number(s)

Name of Account Holder as on Bank or Financial Institution Records

Account Number

Full Name of Bank or Financial Institution

Transit Number &amp; Routing Number

Draft Date  
(1st to 28th only)☐ Checking☐ Savings

Address of Bank or Financial Institution

City

State

Zip Code

I hereby authorize you to make monthly drafts from my account maintained at the above named Bank or Financial Institution. This authorization is limited to payments to the Company in connection with the policy contracts listed above, of:

Monthly Premium Payment of \$ \_\_\_\_\_

Monthly Premium Loan Payment of \$ \_\_\_\_\_

My Bank or Financial Institution has been authorized to pay and charge to my account any withdrawals by and payable to you for this purpose. It will not be necessary for any person employed by the Company to personally authorize such withdrawals. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in making any such withdrawals.

I understand that if any such draft is not honored by my Bank or Financial Institution and any monthly amount due to the Company is not paid within the time stipulated in the policy contract, said policy or contract shall become null and void except as otherwise provided therein. I also understand and agree that if any such draft is not honored, except as a result of an error by the Bank or Financial Institution or the Company, this arrangement may be terminated at the discretion of the Company.

Signature of Account Holder as on Bank or Financial records

Date

**X** \_\_\_\_\_**Attach Voided Blank Check or Deposit Slip Here****IMPORTANT REMINDER**

1. List all policy numbers involved.
2. Send entire form to the Home Office with a Voided Blank Check or Deposit Slip.
3. Please type or print full name and address of Bank or Financial Institution.
4. Draft date will be the Effective Date of the policy unless otherwise specified.
5. Draft date must be the first through the twenty-eighth of the month.

**THIS NOTICE MUST BE DELIVERED TO THE PROPOSED INSURED  
WHEN APPLICATION PART I IS COMPLETED**

**NOTICE CONCERNING THE MEDICAL INFORMATION BUREAU**

Information regarding your insurability will be treated as confidential. Pan-American Life Insurance Company, Pan-American Assurance Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life insurance or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734], telephone (866) 692-6901 (TTY 866-346-3642).

Pan-American Life Insurance Company, Pan-American Assurance Company or its reinsurers may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**FAIR CREDIT REPORTING ACT DISCLOSURE**

In making this application, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation and a written summary of your rights under the Fair Credit Reporting Act.

**ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

To issue an insurance policy we need to obtain information about you. Some of that information will come from you and some will come from other sources. The information collected by us may in certain circumstances be disclosed to third parties without your specific authorization.

You have a right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding.

If you wish to have a more detailed explanation of our information practices, please write to the Underwriting Department, Pan-American Life Insurance Company, P.O. Box 60219, New Orleans, Louisiana. 70160.



☐ Pan-American Life Insurance Company

☐ Pan-American Assurance Company

P.O. Box 60219, New Orleans, LA 70160 USA

Part I of Application (Please print)

**SUPPLEMENTARY APPLICATION**

**to be added to the following Primary Proposed Insured**

1. a) Last Name	b) First Name	c) M. I.	d) Date of Birth
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**Complete a Supplementary Application for each Proposed Insured you want to add**

**ADDITIONAL PROPOSED INSURED**

2. Coverage: <input type="checkbox"/> Spouse Rider <input type="checkbox"/> Additional Insured Rider		3. Relationship to the Proposed Insured:			
4. a) Last Name	b) First Name	c) M. I.	d) Date of Birth	e) Age	f) Gender <input type="checkbox"/> M <input type="checkbox"/> F
g) Social Security Number / Cedula	h) State of Birth	i) Country of Birth (If other than US)	j) Citizenship		k) US Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No
l) Residential Address		m) City	n) State/Province	o) Zip Code	p) Telephone Number
q) E-Mail Address	r) Driver's License Number	s) D.L. State	t) Current Annual Income \$ _____	u) Net Worth \$ _____	
v) Risk Classification (Choose only one from the choices below.) <input type="checkbox"/> Preferred Plus Non-Tobacco <input type="checkbox"/> Preferred Non-Tobacco <input type="checkbox"/> Standard Non-Tobacco <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Standard Tobacco					
5. a) Name of Business (If independent professional, indicate profession.)			b) Nature of Business		
c) Business Address		d) City	e) State/Province	f) Zip Code	g) Business Phone
h) Describe exact duties/functions of Proposed Insured's work.					i) How long in present job?
j) Presently working? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If "No," please explain under question 15, Special Instructions.</small>	k) Other employment in last 3 years		l) Percentage of time traveling and places traveled		

**ADDITIONAL PROPOSED INSURED BENEFICIARIES**

6. a) Full Name of Primary Beneficiary	D.O.B.	Relationship	%	b) Full Name of Contingent Beneficiary	D.O.B.	Relationship	%

If you would like the beneficiary designation to be irrevocable, please indicate this under question 11, Special Instructions.

## EVIDENCE OF INSURABILITY

<b>7. Question must be completed for all (medical/non-medical) insurance.</b>	Yes	No
Have you:		
a) Ever been declined, postponed, rated or modified for life, health or disability insurance?	<input type="checkbox"/>	<input type="checkbox"/>
b) Submitted any application for life, health, or disability insurance or reinstatement of same which is now pending?	<input type="checkbox"/>	<input type="checkbox"/>
c) Ever engaged in any type of flying as pilot or crew member on any aircraft including ultralight planes, or expect to in the future? If "Yes," complete Aviation questionnaire Form B-1200.	<input type="checkbox"/>	<input type="checkbox"/>
d) Participated in any auto or motorcycle racing, scuba diving, parachuting, hang gliding, paragliding, ballooning or expect to in the future? If "Yes," complete Hazardous Sports questionnaire Form B-1201.	<input type="checkbox"/>	<input type="checkbox"/>
e) Within the past five years been convicted of or pleaded guilty to:		
(1) Two or more moving violations and/or accidents?	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes," include Driver's License No. _____		
(2) Driving under the influence of alcohol and/or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
f) Ever been arrested other than for moving violations?	<input type="checkbox"/>	<input type="checkbox"/>
g) If not a US citizen or legal resident of the US and residing permanently outside of the US, do you have any intention of traveling or living in another country in the next two years? If "Yes," indicate where and how long.	<input type="checkbox"/>	<input type="checkbox"/>
h) Are any of the Proposed Insureds residing in a country other than the US:		
(1) Presently in or held any political positions?	<input type="checkbox"/>	<input type="checkbox"/>
(2) Currently in or has served in the Armed Forces?	<input type="checkbox"/>	<input type="checkbox"/>
(3) Currently in or held any governmental positions?	<input type="checkbox"/>	<input type="checkbox"/>
i) (1) In relation to purchasing this policy, have you been offered cash or other valuable consideration as an incentive for you to purchase the policy?	<input type="checkbox"/>	<input type="checkbox"/>
(2) Have there been any representations made to you in connection with the purchase or financing of this policy to the effect that the insurance is free or without cost to you for any period of time?	<input type="checkbox"/>	<input type="checkbox"/>
(3) Does your purchasing this policy include a financing arrangement where a lender or other third party will receive a portion of the death benefit above and beyond the repayment of principle and interest?	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes," provide details below.		

Details of "Yes" answers. Identify question letter and circle applicable items.

**8. Insurance currently in force on each person proposed for insurance(Life, Health, Disability, Long Term Care policies or riders to other policies)**  
**If applicant has indicated existing insurance or annuity contracts on below question, our notice #3535 (NAIC 2000) must be executed.**

Insurance Company	Policy Number	Year of Issue	Amount of Insurance	Accidental Death Amount	Premium Waiver
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

PERSONAL DATA		FAMILY HISTORY							
<b>9 a). PROPOSED INSURED</b>		<b>b) Relationship</b>	<b>Age if living</b>	<b>Age at death</b>	<b>Cause of death</b>	<b>c) Relationship</b>	<b>Age if living</b>	<b>Age at death</b>	<b>Cause of death</b>
Height (Ft/Cm)	Weight (Lbs/Kg)	Father				Brothers			
		Mother				Sisters			

**Answer question 10 if cash intended to be paid with this application.**  
**If "Yes" to either (a) or (b), cash cannot be accepted and conditional receipt must not be given.**

<b>10. Within the past 12 months have you:</b>	Yes	No
a) Been medically diagnosed with or treated for heart trouble, stroke, or cancer, consulted a physician for blood pressure requiring medication, or had an electrocardiogram made for any reason other than a routine physical examination?	<input type="checkbox"/>	<input type="checkbox"/>
b) Are you contemplating hospitalization, surgery or other medical treatment in the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>

**11. Special Instructions**

## HEALTH STATEMENT

12. a) Personal Physician Last Name	b) Personal Physician First Name	c) E-mail Address	
d) Physician's Address	e) City	f) State/Province	g) Zip Code
h) Telephone Number			

13. To the best of your knowledge and belief within the last 10 years, have you been medically diagnosed with or treated for:

MEDICAL CONDITION	Yes	No	MEDICAL CONDITION	Yes	No
a) Disorders of the eyes, glaucoma, cornea? Do not include usual vision correction lenses or routine eye check ups.	<input type="checkbox"/>	<input type="checkbox"/>	l) Skin cancer, surgical scars, non surgical scars, other lesions or disorders of the skin?	<input type="checkbox"/>	<input type="checkbox"/>
b) Disorders of the ears, nose or throat, or hoarseness?	<input type="checkbox"/>	<input type="checkbox"/>	m) Anemia, leukemia, hemophilia, phlebitis, thrombophlebitis or any disorders of the blood, vascular system or spleen? Received a blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>
c) Seizures, convulsions, stroke, cerebral infarct, TIA, severe migraines, recurrent or unexplained headaches, epilepsy, dizziness, dizzy spells, aneurysm, paralysis, quadriplegia, mental/nervous disorders or any other disorders of the brain?	<input type="checkbox"/>	<input type="checkbox"/>	n) Benign or malignant tumors, cancer, cysts, or lymph gland disorders?	<input type="checkbox"/>	<input type="checkbox"/>
d) Pneumonia, bronchitis, asthma, emphysema, allergies, persistent cough, tuberculosis, blood spitting, hemoptysis, chronic respiratory disorder, or any other respiratory or lung disorders?	<input type="checkbox"/>	<input type="checkbox"/>	o) Do you smoke cigarettes, pipe or cigars, or use tobacco in any form? Indicate quantity and frequency.	<input type="checkbox"/>	<input type="checkbox"/>
e) Urinary or genital disorders, kidney stones, renal failure, renal or kidney infections, urinary tract infections, cysts, prostatitis, or sexually transmitted diseases?	<input type="checkbox"/>	<input type="checkbox"/>	p) Have you quit smoking? Indicate when: <input type="checkbox"/> 1 yr <input type="checkbox"/> 2 yrs <input type="checkbox"/> 3 yrs <input type="checkbox"/> 10 or more	<input type="checkbox"/>	<input type="checkbox"/>
f) Hepatitis, cirrhosis, gallbladder stones, cholecystectomy, cholecystitis or any other disorders of the liver or gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>	q) Have you had an EKG, X-Ray, or other diagnostic test?	<input type="checkbox"/>	<input type="checkbox"/>
g) Tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	<input type="checkbox"/>	<input type="checkbox"/>	r) Have you within the past five years: 1) Had a check-up, illness, injury or surgery? 2) Been advised to have any diagnostic test or surgery which was not completed? 3) Are you contemplating hospitalization, surgery or other medical treatment in the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
h) Hyperthyroidism, hypothyroidism, thyroiditis, diabetes mellitus type I or II, goiter, hypoglycemia, blood sugar, disorders of the pancreas, parathyroid glands or endocrine disorders?	<input type="checkbox"/>	<input type="checkbox"/>	s) Has any immediate family member ever been medically diagnosed with or treated for diabetes, cancer, heart disease, or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
i) Duodenal ulcer, gastric ulcer, dyspepsia, indigestion gastritis, intestinal bleeding, diverticulitis or diverticulosis, hemorrhoids, colitis, constipation, esophagitis, hiatal hernia, or any other disorders of the digestive system?	<input type="checkbox"/>	<input type="checkbox"/>	t) Have you been treated for alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
j) High blood pressure, myocardial infarction, heart attacks, murmurs, valve lesions, varicose veins, palpitations, tachycardia, chest pain, coronary heart disease, aneurysm, anemia, rheumatic fever, Chagas disease or any other cardiovascular disorder?	<input type="checkbox"/>	<input type="checkbox"/>	u) Are you currently under observation or treatment by a physician or a medical facility?	<input type="checkbox"/>	<input type="checkbox"/>
k) Arthritis, neuritis, gout, sciatica, rheumatism, or disorders of the muscles, bones, spine, back or joints, herniated discs, rheumatoid arthritis, osteoporosis or immune (connective tissue) diseases?	<input type="checkbox"/>	<input type="checkbox"/>	v) For men over 50 years old: 1) Have you had a prostate check up? 2) Have you had a PSA test? Indicate dates and results below.	N/A	<input type="checkbox"/>
			w) For Women: 1) Disorders of the ovaries, uterus, breast, lumps, abnormal discharge, or any other gynecological or breast disorder? 2) Have you had a mammogram, PAP smear or gynecological check up recently? Indicate dates, name(s) of physician(s) and results. 3) Are you pregnant? Indicate how many weeks (or months): _____	<input type="checkbox"/>	<input type="checkbox"/>

14. Details of "Yes" answers. Identify question letter and circle applicable items. Include diagnosis, dates, durations, treatments, names, addresses, emails and phone number of doctors or medical facilities.

Question Letter	Diagnosis and treatment of medical conditions or check ups	Name and address/phone/emails of Doctors or Hospitals	Dates

## DECLARATION

To the best of his or her knowledge, information and belief, the Proposed Insured (Parent or Guardian if Proposed Insured is under age 18) and Owner (if other than Proposed Insured, Parent or Guardian) represent that the answers and statements made in Parts I (including any supplementary applications) and II (if Part II is required by the Company) of this application are complete and true. The undersigned agrees that:

1. No waiver or modification of a contract provision or of any of the Company's rights or requirements shall be binding upon the Company unless made in writing and approved by the Company;
2. The acceptance of any issued contract will ratify any changes made by the Company in the space "For Home Office Endorsements." However, changes in plan of insurance, amount, age at issue, classification of risk or benefits will be made only with the Owner's written consent;
3. If, within 60 days from the date of application, no policy is received or I am not notified of approval or rejection, this application shall be deemed declined;
4. \$ \_\_\_\_\_ for life insurance has been paid in cash and the Company's liability will be as stated in the Conditional Receipt. (No other receipt will be valid);
5. If no payment is made with this application, there will be no life insurance or liability
  - a) until a policy is delivered;
  - b) until the first full premium is paid during the Insured's lifetime; and
  - c) as long as no change has occurred in the health of any person proposed for insurance that would place that person in a higher risk class than at the time of application for this policy; and
6. Any contract resulting from this application shall be construed in accordance with the laws of the state named below where this application is signed.

## FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject of fines and confinement in prison.

## MEDICAL INFORMATION BUREAU AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. ("MIB"), consumer reporting agency or other organization, institution or person that has any records or knowledge of me or my minor child or my health or my minor child's health to give to the Pan-American Life Insurance Company, Pan-American Assurance Company, or its reinsurers any such information in order to evaluate my application for life or disability insurance.

I agree that this authorization shall be valid for 30 months from the date signed.

I know that I may request a copy of this authorization.

I agree that a photographic copy of this authorization shall be as valid as the original.

The Undersigned acknowledges receipt of the Notice Concerning the Medical Information Bureau, the Fair Credit Reporting Act Disclosure, and the Abbreviated Notice of Insurance Information Practices.

I understand that I may be interviewed if an investigative consumer report is prepared in connection with this application.

### 15. For Home Office Endorsements (For Home Office use only)

Signed at (City)			State		Date signed		
Signature of <b>Additional Insured</b> (Parent or Guardian, if Proposed Insured under age 18) <b>X</b> _____			Signature of <b>Owner</b> (If other than Proposed Insured) (If Corporation or Partnership, Officer or Partner other than Proposed Insured must sign.) <b>X</b> _____				
I hereby certify that I have truly and accurately recorded on this application the information supplied by the applicant and that I have personally seen this Proposed Insured under this application. To the best of my knowledge, replacement of insurance <input type="checkbox"/> is <input type="checkbox"/> is not involved in this transaction.							
Signature of Soliciting Agent <b>X</b> _____		Personal Code	Participating %	Signature of Soliciting Agent <b>X</b> _____		Personal Code	Participating %
Soliciting Agent's Printed Name			Soliciting Agent's Printed Name				
Signature of Soliciting Agent <b>X</b> _____		Personal Code	Participating %	Signature of Soliciting Agent <b>X</b> _____		Personal Code	Participating %
Soliciting Agent's Printed Name			Soliciting Agent's Printed Name				

**HIPAA AUTHORIZATION FOR THE USE  
AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I authorize the use and/or disclosure of the protected health information of \_\_\_\_\_ as described below:

1. This authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization: All medical records and other protected health information concerning the above named individual.
2. I authorize the following persons (or class of persons) to disclose the protected health information:  
Any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, benefit manager, medical facility, insurance company, insurance support organization or other health care provider that has provided payment, treatment or services to or on behalf of the above named individual.
3. I authorize the following persons (or class of persons) to receive the protected health information:  
Pan-American Life Insurance Company and/or Pan-American Assurance Company and/or \_\_\_\_\_  
\_\_\_\_\_
4. I understand that, if the protected health information is disclosed to someone who is not required to comply with the federal privacy regulations, then such information may be re-disclosed and would no longer be protected.
5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing to Pan-American Life Insurance Company, HIPAA Compliance Officer, 601 Poydras Street, New Orleans, LA 70130. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose the protected health information have acted in reliance upon this authorization.
6. This authorization expires upon six months after the date of signature below.
7. I understand that I do not have to sign this authorization. However, I understand that my claim for benefits or my application for insurance coverage may not be processed until all of the necessary information needed to complete the claims and/or underwriting process has been received by Pan-American.
8. The protected health information will be used or disclosed upon request for the following purposes:  
To furnish the insurer with information necessary to complete the processing of an application for life, health and/or disability insurance, and/or to furnish the insurer with information necessary to complete processing of a life and/or disability claim.
9. I understand that I have a right to inspect and copy the protected health information to be used or disclosed in accordance with the requirements of the federal privacy protection regulations.

I certify that I have received a copy of this authorization.

Signature <b>X</b> _____	Name _____	Date _____
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SERFF Tracking Number:	PNAL-127029274	State:	Arkansas
Filing Company:	Pan-American Life Insurance Company	State Tracking Number:	48014
Company Tracking Number:	SJL-480		
TOI:	L08 Life - Other	Sub-TOI:	L08.000 Life - Other
Product Name:	Applications B1500 and B1501		
Project Name/Number:	Applications B-1500, B-1501/SJL-480		

## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b>	AR Cover letter	
<b>Comments:</b>		
AR Cover letter		
<b>Attachment:</b>		
AR cover letter.pdf		





**San J. Llull**  
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(504-566-3447)

February 10, 2011

NAIC # 67539  
FEIN # 72-0281240

Mr. Jay Bradford  
Insurance Commissioner  
State of Arkansas  
1200 W. Third Street  
Little Rock, AR 72201

**RE: Applications B-1500 (AR) and B-1501(AR)**

Dear Mr. Bradford:

The above applications were approved by your state on 04-06-2007. Now we are re-filing for your approval the same forms with two additional issues very important to the insurance industry:

- STOLI
- ANTI-MONEY LAUNDERING.

On page 3 of B-1500(AR) and page 2 of B-1501(AR) we added 11-(i) and 7-(i) respectively questioning information about STOLI.

On page 7 of B-1500 (AR), in the Agent's Report we added 1n Q-4 the wording "and reviewed forms of identification" to be compliant with the Anti-Money Laundering issues.

Enclosed please find our updated forms with the date of these changes.

1. Primary Proposed Insured Application **B-1500 (AR) Rev. 01-11**
2. Supplemental Application **B-1501 (AR) Rev. 01-11**

If you need further information, you may contact me at 504-566-3449. Thank you for your time and consideration.

Sincerely,

San J. Llull  
Senior Compliance and Policy Analyst